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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Derakhsh Fozouni, M.D.** **555 E. Tachevah Drive** **Suite 2W-103** **Palm Springs, CA 92262** **Physician's and Surgeon's Certificate No. A 95051,** Respondent.	Case No. 800-2016-027417 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 21, 2006, the Board issued Physician's and Surgeon's Certificate No. A 95051 to Derakhsh Fozouni, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2021, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
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> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> . . .

6. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> . . .
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> (b) Gross negligence.
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> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

. . .

7. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A 95051 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A, as more particularly alleged hereinafter:[1]

9. On or about December 8, 2014, Patient A attended her first obstetric visit with Respondent. On this visit, Patient A was 10.5 weeks pregnant and her due date was July 2, 2015. Patient A continued to see Respondent through on or about June 22, 2015. During a visit that took place on or about May 18, 2015, Patient A's abdominal circumference measured at 37 weeks, while the remaining measurements were at 33 weeks. Patient A was 34 weeks and 1 day pregnant on this visit. Respondent noted "poor nutrition" and that he discussed "poor outcome[s] and potential issues with birth and injury" with Patient A and her husband.

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[1] References to "Patient A" herein are used to protect patient privacy.

10. On or about the early morning of June 25, 2015, Patient A went to the hospital by ambulance. When speaking with Nurse P.M., the triage nurse, Patient A complained of leaking clear fluid before 3:00 a.m. At approximately 3:50 a.m., Nurse P.M. noted SROM (Spontaneous Rupture of Membranes), negative GBS (Group B Streptococcus), and "Fluid: thick meconium."[2] The meconium was described as large in quantity and odorless. Patient A was admitted to the hospital at approximately 4:16 a.m.

11. At approximately 5:01 a.m., Nurse P.M. spoke with Respondent by telephone regarding Patient A. Nurse P.M. relayed Patient A's complaints to Respondent, who then ordered Pitocin[3] to be started at 6:00 a.m.

12. At approximately 10:46 a.m., Nurse A.N. spoke with Respondent by telephone regarding Patient A and notified him of "prolonged decel[eration], SVE [sterile vaginal exam], contraction frequency, pitocin off, and interventions done." Respondent ordered that they wait for half an hour more to restart Pitocin and, if the prolonged decelerations continued, to do an amnioinfusion.

13. At approximately 2:30 p.m., Respondent was at the nurse's station reviewing the fetal heart rate (FHR) tracing. He was aware of Patient A's decelerations. Nurse A.N. noted that no new orders were received from Respondent. Respondent did not document any corresponding assessment or plan, nor the rationale for his decision-making at that time.

14. At approximately 5:00 p.m., Respondent was at the nurse's station and was notified of an SVE, Pitocin dose, and MVUs (Montevideo units). Nurse A.N. noted that no new orders were received. Respondent did not document any corresponding assessment or plan, nor the rationale for his decision-making at that time.

15. From approximately 6:15 a.m. until approximately 5:44 p.m., the presence of meconium was documented numerous times in the nurse notations. No subsequent notations regarding meconium were made until the next day during the C-section delivery.

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[2] Meconium is the baby's first stool, or poop, which is sticky, thick, and dark green. It is typically passed in the womb during early pregnancy and again in the first few days after birth.

[3] Pitocin is the synthetic version of oxytocin, a natural hormone that helps the uterus to contract during labor.

16. At approximately 7:19 p.m., Respondent was at the nurse's station and ordered that Pitocin be stopped at that time, restarted at 2:00 a.m., and then increased every 20 minutes thereafter by two milliunits. Respondent did not document any corresponding assessment or plan, nor the rationale for his decision-making at that time.

17. Between approximately 7:00 p.m. and 7:30 p.m., Respondent visited Patient A and her husband. According to a notation entered at approximately 7:15 p.m. by Nurse D.P., the plan of care was discussed with, and agreed to, by Patient A and her family. Respondent did not document this patient encounter, including any discussions he had with Patient A and her husband regarding the plan of care, the rationale for the plan of care, or any information relating to SROM, meconium, dilation, or the timing and need for a C-section.

18. At approximately 11:45 p.m., Respondent was at the nurse's station reviewing the FHR tracing. Nurse D.P. informed Respondent of Patient A's recurrent late decelerations. Respondent ordered Pitocin to be stopped and to prepare Patient A for a C-section in the morning. Respondent did not document any corresponding assessment or plan, nor the rationale for his decision-making regarding the C-section at that time.

19. The next day, on or about June 26, 2015, at approximately 4:32 a.m., Nurse D.P. spoke with Respondent and notified him of Patient A's recurrent late decelerations, UC (uterine contraction) pattern, and current temperatures, including a temperature of 100.1°F. Respondent stated that Terbutaline[4] may be given to Patient A and to consent Patient A for a C-section. Respondent further stated that he would perform a C-section in the morning.

20. At approximately 5:00 a.m., Patient A signed a hospital consent form for a primary C-section. According to a nursing note that was belatedly entered at approximately 7:50 a.m., Respondent was at Patient A's bedside and obtained her informed consent for a C-section.

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[4] Terbutaline is a medication used to delay preterm labor. It belongs to a class of drugs called betamimetics, which help to prevent and slow contractions of the uterus.

21. According to a late entry nurse note, prior to approximately 7:39 a.m., Respondent was at the nurse's station. Nurse H.A. asked Respondent if he wanted to proceed with Patient A's case first or another scheduled case. Respondent decided to proceed with the other scheduled case.

22. According to a late entry nurse note, prior to approximately 7:45 a.m., Respondent was at the nurse's station reviewing the FHR tracings. Nurse L.N. noted that they were to get Patient A ready for a C-section "to follow the scheduled case."

23. On or about June 26, 2015, prior to the C-section surgery, Respondent completed and signed a "Physician Progress Note – Obstetrical Pre-Delivery Assessment Note." Respondent did not document the presence of thick meconium in his note.

24. At approximately 9:17 a.m., Patient A was transferred to the operating room. According to Respondent's operative report, the indication for surgery was "failure to dilate."

25. By the time of the C-section surgery, Patient A had been at 5 cm dilated since approximately 5:44 p.m. the previous day, a period of almost 16 hours. Patient A also had documented ruptured membranes for a period of almost 31 hours, having spontaneously ruptured at approximately 3:00 a.m. the previous day. In addition, Patient A had documented thick meconium. Since approximately 4:15 a.m. the previous day, Patient A also had nine SVEs and two internal devices placed, *i.e.*, an intrauterine pressure catheter and a fetal scalp electrode.

26. At approximately 9:56 a.m., Patient A gave birth to a baby girl. In his operative report, Respondent noted the presence of "[e]xtremely thick meconium" and "foul amniotic fluid" during the delivery. The baby required immediate resuscitation and intubation, and was promptly taken to the NICU department and, subsequently, to another hospital. The baby passed away later that night. The documented causes of death were cardiorespiratory failure, severe hypoxemia, severe hypotension, and septic shock from bacterial infection.

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27. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to the following:

(a) On or about June 26, 2015, prior to approximately 7:39 a.m., Respondent delayed in proceeding with Patient A's C-section delivery in order to perform the scheduled C-section delivery of another patient, despite the presence of multiple, worsening risk factors that rendered Patient A's condition non-elective.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

28. Respondent has subjected his Physician's and Surgeon's Certificate No. A 95051 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 27, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

29. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but were not limited to the following:

(a) On or about June 26, 2015, prior to approximately 7:39 a.m., Respondent delayed in proceeding with Patient A's C-section delivery in order to perform the scheduled C-section delivery of another patient, despite the presence of multiple, worsening risk factors that rendered Patient A's condition non-elective.

(b) On or about June 26, 2015, at approximately 4:32 a.m., Respondent delayed in proceeding with Patient A's C-section delivery and did not follow up to provide a definitive C-section in a timely fashion, despite ongoing indications of Patient A's failure to progress and the presence of multiple risk factors.

(c) Respondent did not document an encounter with Patient A that took place on or about June 25, 2015, between approximately 7:00 p.m. and 7:30 p.m., including his discussion with Patient A and her husband regarding the plan of care, the rationale for the plan of care, or any information relating to SROM, meconium, dilation, or the timing and need for a C-section.

(d) Respondent did not document any assessment or plan regarding his decision on or about June 25, 2015, to perform a C-section the following morning, nor did he document the rationale for his decision-making relating to the C-section.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

30. Respondent has subjected his Physician's and Surgeon's Certificate No. A 95051 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 29, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

31. Respondent has subjected his Physician's and Surgeon's Certificate No. A 95051 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged hereinafter:

32. On or about June 22, 2015, Patient A had her last office visit with Respondent. Patient A's spouse was also present during the visit. Respondent performed a cervical exam on Patient A, during which he stated to Patient A: "Oh, I bet you like that."

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 95051, issued to Respondent Derakhsh Fozouni, M.D.;

2. Revoking, suspending or denying approval of Respondent Derakhsh Fozouni, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Derakhsh Fozouni, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 26, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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